

December 12, 2002

MDR Tracking #:

M2-03-0375-01

IRO #:

5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 41-year-old woman who injured her lower back on ___, while working for ___ as a packer. It is noted that the patient did not report her injury until about seven months after the original injury when she presented to her occupational medicine clinic. ___ had x-rays and was diagnosed with a sprain.

___ past medical history is significant for a low back sprain in ___ when she was involved in a motor vehicle accident.

The patient came under the care of ___ approximately eight months after the injury. She underwent three months of chiropractic treatment with no resolution.

She was seen by ___, an orthopedic surgeon. She was then sent to ___, a pain management physician.

___ has had an MRI which demonstrated multi-level disc disease. A discogram was negative at L3-L4, L4-L5, and L5-S1. It is also noted that on August 12, 2001, ___ performed an EMG/Nerve conduction Study of the lower extremities which was negative.

Apparently an IDET was requested but denied. Records indicate ____ is requesting another MRI and EMG/NCS. There are notes in the records that suggest ____ asked to do a 360 degree fusion at L5-S1.

In June of 2002, ____ was seen by ____ at the Impairment Evaluation Center in _____. He served the function of a designated doctor. At that time, she was complaining of lower back pain, stating that it radiated to the posterior thighs. There is no weakness, no bowel or bladder problems, no fevers or chills. ____ complains of numbness and tingling in the lateral legs. It is noted that the patient has not worked since the injury.

Her physical examination demonstrated she was 63” and weighs in excess of 230 pounds. Her lumbar examination is negative for any radiculopathy or radiculitis.

REQUESTED SERVICE

A Repeat EMG/NCS of bilateral lower extremities is requested for ____.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

____ is a 41-year-old woman who has sustained a low back injury on _____. As a result of the injury she sustained a lumbar sprain/strain. She has reached maximum medical improvement.

Based on the medical records provided, specifically the patient’s examination which is essentially unremarkable with negative x-rays, negative EMG/NCS of the lower extremities, and an unremarkable MRI of the lumbar spine with discogram, the reviewer finds that a repeat EMG/NCS would be unwarranted in this patient. Please note there is no clinical evidence that this patient has radiculopathy. It is also noted that this patient is some two years post-injury and is complaining of low back pain only with no clinical evidence of radiculitis/radiculopathy.

As an officer of _____, dba _____, I certify that there is no known conflict between the reviewer, _____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).